TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LONESTAR HEALTHCARE GROUP

MFDR Tracking Number
M4-13-1463-02

MFDR Date Received
February 12, 2013

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services rendered to [injured employee] on 08/15/2012 were administered here in the physician's office therefore do not meet the criteria for which precert/preauth is required."

Amount in Dispute: $1,310.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the dispute packet submitted by the Robert Khan MD and will maintain its denial for ANSI code 197 – Payment denied/reduced for absence of precertification/ preauthorization. Review of the Low Back chapter of the ODG (Exhibit A) does not show a recommendation for a 3 level fact injection to include a SI Joint injection. With these findings, the Office maintains procedures needed to be reviewed by a utilization review physician to substantiate the medical necessity."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2012	64493-50, 64494-50, 64495-50, 27096-50-59 and 77003	$1,310.00	$0.00

FINDINGS AND DECISION

The Division withdrew a findings and decision issued on June 5, 2014 under MDR M4-13-1463-01 on June 11, 2014. This MDR Findings and Decision **supersedes** and replaces any and **all previous** findings and decisions between the parties in this dispute.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §137.100 sets out the treatment guidelines for disability management.
3. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - Note: Current medical from the physician does not support the treatment, service provided, and/or do not appear to be within the ODG treatment guidelines (Rule 137.100) for he indicated DX. Per Rule 134.600 (p)(12) carrier is not liable for treatment and/or services provided in excess of the divisions treatment guidelines unless in an emergency or pre-authorization rules.

Issues

1. Did the services in dispute require pre-authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 64493, 64494, and 64495 – lumbar facet joint injections – 3 levels bilaterally and 27096 – SI joint injections bilateral and CPT Code 77003 – fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures rendered on August 15, 2012. The insurance carrier denied/reduced the disputed services with denial/reduction code "197 – Payment denied/reduced for absence of precertification/authorization."

   Pursuant to 28 Tex. Admin. Code §134.600(p)(12) treatment and services that exceed or are not addressed by the

   Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier requires preauthorization. The Respondent states in their position summary that "The services rendered to [injured employee] on 08/15/2012 were administered here in the physician's office therefore do not meet the criteria for which precert/preauth is required."

   Pursuant to rule §137.100(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning).

   Per the ODG for August/2012 lumbar facet joint injections and SI joint injections are not recommended and therefore would require pre-authorization under rule §134.600(p)(12). Non-emergency health care requiring preauthorization includes: treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier. The requestor submitted insufficient documentation to support that the disputed services were preauthorized as required by 28 Texas Administrative Code 137.100. For this reason, reimbursement for the disputed services is not recommended.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed services rendered on August 15, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 17, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.